New Beginnings Chiropractic

CONSENT TO TREATMENT AND RESPONSIBILITY AGREEMENT

Please read each section carefully. You may request a copy of this form for your own records.

Please print your name: ________________________________

I, the undersigned, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgment for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I consent to the customary examinations, tests and procedures performed at or by New Beginnings Chiropractic ("clinic") and to routine chiropractic treatment ordered or administered by my chiropractor or other staff members. I recognize that the practice of chiropractic is not an exact science and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fracture, disc injuries, muscle or vertebral strains, arterial dissection or others.

I understand and agree that the doctors of **New Beginnings Chiropractic** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

I understand a notice of 24 hours is required for cancelled appointments. I understand that my time slot is only for me and that by skipping an appointment without canceling means that someone in need is unable to be seen.

I hereby authorize the release of my medical records and other information necessary to process insurance claims.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature_______________________________________ Date_____________________________